For DHHS Use Only

CON Application Number
Facility Number
Date Submitted

APPLICATION FOR CERTIFICATE OF NEED

Michigan Department of Health & Human Services

CERTIFICATE OF NEED

South Grand Building
333 S. Grand Avenue, 4th Floor
Lansing, Michigan 48933

Phone: (517) 241-3344 Fax: (517) 241-2962

AUTHORITY: PA 368 of 1978, as amended **COMPLETION:** Is voluntary, but is required to obtain a Certificate of Need. If not completed, a Certificate of Need will not be issued.	The Department of Health & Human Services is an equal opportunity employer, services and programs provider.

1. Legal Name of Applicant *(Must be exactly the same as Section 2 on Letter of Intent)*			
2. Current Name of Facility			County
3. Proposed Name of Facility			
4. Current Facility Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

5. FACILITY TYPE*: (Check one and explain as needed)*

- ☐ **Hospital**
- ☐ **Long Term (Acute) Care Hospital**
- ☐ **Hospital Long Term Care Unit**
- ☐ **Nursing Home**
- ☐ **Freestanding Surgical Outpatient Facility**
- ☐ **Psychiatric Hospital**
- ☐ **Inpatient Psychiatric Unit**
- ☐ **Health Maintenance Organization**
- ☐ **Other – Not a Licensed Health Facility (Specify):**

6. Current Legal Owner of Building *(if other than applicant)*			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
7. Proposed Legal Owner of Building *(if different than item 6)*			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
8. Current Licensee of Licensed Health Facility or CON Approved Operator of Non-licensed Facility *(if other than applicant)*			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

CERTIFICATIONS

A. I certify that the information and attachments submitted are true and correct. I further certify that no revisions will be made to the approved project, including bed count or provision of additional or expanded services and space, without first notifying and receiving approval from the Department of Health & Human Services to make such revisions.

B. I understand that the Certificate of Need application process, decision, and subsequent operation of the proposed project (if approved) are subject to the applicable laws, rules, and CON Review Standards**.**

C. I understand that a signed certification form or electronic submission agreeing to comply with the CON Review Standards applicable to this project must be included in this application.

D. I understand that nonsubstantive review under Rule 205(4) of the Certificate of Need Administrative Rules generally is granted only for those projects that are exclusively within the predesignated categories.

CERTIFICATION ACCEPTANCE

Signature of Authorized Agent	Date Signed

CERTIFICATE OF APPOINTMENT FOR AUTHORIZED AGENT

Notice is hereby given to the Michigan Department of Health & Human Services that:

_____

[Legal name of applicant entity (same as Page 1, Line #1)]

has appointed and authorized the following person to act on behalf of the applicant entity.

Agent Name	Title		
Name of Agent's Organization			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Agent's Telephone Number Extension	Agent's Fax Number Extension		
Agent's E-Mail Address			

The above named agent is the authorized representative for Certificate of Need Number:

_____

(Certificate of Need Number)

The above named agent is authorized to do the following:

A. submit this Certificate of Need application and make amendments thereto,

B. provide the Department with all information necessary for a determination with respect to this Certificate of Need application,

C. enter into agreements with the Department in connection with this Certificate of Need, and

D. receive notice and service of process in matters relating to this Certificate of Need.

- This appointment will remain in effect for this application until written notice of termination is sent to the Michigan Department of Health & Human Services that references the specific CON Application number.
- The termination notice must identify a new authorized agent.

Typed Name	Signature of Individual Legally Authorized to Appoint Agent *(Original signature only)*
Title	

OTHER CONTACT PERSONS:

FINANCIAL DATA: (Person's Name)	ALL OTHER DATA: (Person's Name)
Telephone Number Extension	Telephone Number Extension
E-mail Address	E-mail Address

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

1. Legal Name of Applicant Entity *(same as Line #1 on Page 1)*			
Applicant d/b/a *(applicable to this application, if any)*			Date Legal Entity was Formed
Employer Identification Number (EIN)	Telephone Number		Extension
Agent Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

2. Ownership/Controlling Interest:

- Identify below all individuals/organizations (including partnerships) that have direct ownership or a controlling interest in the applicant entity. For all individuals, list both their names and addresses.
- If any of the individuals is related to each other, the relationship must be reported under Item 6, "Remarks," on Page 5 of this form. List the organization's EIN (including partnerships).
- For corporations, list the names and addresses of the corporation's directors as well as the EIN for the corporation.

(Use additional sheets as needed)

Individual / Organization Name	Employer Identification No.	Phone Number	
A.			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
B.			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
C.			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
D.			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
E.			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

3. Type of Entity:

☐ Corporation, for-profit Sole
☐ Corporation, not-for-profit
☐ Government
☐ Partnership, type:
☐ Religious
☐ Sole Proprietorship
☐ Unincorporated Associations
☐ Other (specify):

4. Does anyone listed in Item 2 above also own other health-care facilities (for example: sole proprietor, partner, member of a partnership, board of directors)?

☐ NO ☐ YES ▶

- If "yes," list names below, addresses of the other health-care facilities owned, and each facility's EIN.
- (Use additional sheets as needed)

Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

5. Is the applicant facility chain affiliated?

☐ NO ☐ YES *(If "yes," provide the information requested below. Use additional sheets as needed.)*

Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Individual / Organization Name	Employer Identification No.	Phone Number	
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

6. REMARKS*: (Use additional sheets as needed)*

7. For non-profit health facilities only, list the voting members of the governing body by total number of consumers, providers, males, and females.

VOTING MEMBER CATEGORY	TOTAL NUMBER
CONSUMERS	
PROVIDERS	
MALES	
FEMALES	

PROJECT TIMETABLE

1. Date contract to be signed with an architect / engineer registered in Michigan _____
2. Date schematic plans and narrative will be complete _____
3. Completion date for design development plans with revised cost estimate _____
4. Date for determination of methods of financing and ability to finance _____
5. Date of final architectural plans and specifications _____
6. Date of receipt of bids or vendor quotation(s) _____
7. Date of obligation for capital expenditure *(see ❶ below)* _____
8. Date contracts to be let _____
9. Date of initiation of construction _____
10. Date equipment will be installed, if applicable _____
11. Date of completion of construction *(see ❷ below)* _____
12. Date services associated with this project will begin _____

❶ An obligation for a capital expenditure shall be deemed to have been incurred by or on behalf of an institution:

A. When an enforceable contract is entered into by such institution or by a person representing such institution, for the construction, acquisition, lease, and/or financing of a capital asset;
B. Upon the formal, internal commitment of funds by such institution for a force account expenditure that constitutes a capital expenditure; or
C. In the case of donated property, the date the gift is completed in accordance with applicable Michigan laws.

❷ If major components of the proposed project will be completed and become operational prior to the overall completion of the project, indicate below the anticipated dates of completion for each component.

Component / Department	Anticipated Completion Date